J Orthop Sci (2006) 11:233–234
DOI 10.1007/s00776-006-1030-0

JOURNAL OF
ORTHOPAEDIC SCIENCE

Editorial

On Convening the 39th Annual Musculoskeletal Tumor Meeting of the Japanese Orthopaedic Association

Takeo Matsuno

Department of Orthopaedic Surgery, Asahikawa Medical College Hospital, 2-1-1-1 Midorigaoka-higashi, Asahikawa 078-8510, Japan

Nearly 40 years have passed since the 1st Annual Musculoskeletal Tumor Meeting of the Japanese Orthopaedic Association (called the Forum of the Society for Musculoskeletal Tumors at that time) was held in 1968. Although the surgical field of musculoskeletal tumors has markedly advanced since then, the cooperation of orthopedic surgeons with pathologists and radiologists and collaboration with other medical practitioners are still insufficient. On the convening of the 39th Annual Musculoskeletal Tumor Meeting of the Japanese Orthopaedic Association on July 6 and 7 this year at the Sapporo Convention Center, I would like to share my thoughts on the Annual Musculoskeletal Tumor Meeting and on the diagnosis and treatment of musculoskeletal tumors that we encounter in routine practice.

After graduating from Hokkaido University, I started my career as a pathologist, which I pursued for 7 years. The first time I participated in the Annual Musculoskeletal Tumor Meeting ("Forum" at that time) was at the 4th meeting, convened in 1971 by Dr. Maeyama, Professor of Orthopedics, Tottori University. Everything was stimulating for me, just 1 year after my graduation. I cannot forget the heated discussions between participants (orthopedic surgeons and pathologists) on histological diagnosis in case-report sessions. One thing I felt at that time and still feel today is the importance of thorough discussion of conventional H&E-stained samples. Diagnosis based on H&E staining tends to be disregarded because diagnosis by immunohistological staining has advanced, but this is the wrong order of priority. It is time to reconsider diagnosis beginning with H&E staining. Secondly, cooperation between orthopedic surgeons and pathologists or radiologists remains insufficient: lack of information provided by orthopedists was an issue raised by pathologists at that time (35 years ago). Very few skeletal radiologists participated in the meeting then, and cooperation between orthopedic surgeons and pathologists or radiologists is still insufficient. I feel strongly that this situation is causing problems such as misdiagnosis.

I experienced culture shock concerning this matter several years later when I went to Boston to study. After I had completed a 3-year pathology residency, I studied at the Surgical Pathology Department of Massachusetts General Hospital (MGH) in Boston. On my first day in the Surgical Pathology Department, I was asked about X-ray diagnosis of bone tumor, not pathological diagnosis, although I went there as a pathologist. Because pathologists did not examine X-rays at that time in Japan, I was at a loss. I learned later that bone pathologists taught X-ray diagnosis of bones to residents in orthopedic surgery as well as to radiology residents at MGH at that time. I felt that accurate X-ray diagnosis was impossible without understanding histopathology.

Considering how much my perception and "shock" have changed after 40 years, on the occasion of this Annual Musculoskeletal Tumor Meeting, I cannot help feeling that the situation is still unsatisfactory. Thus, these problems have been incorporated into the keynote theme, symposia, and panel discussions for the meeting. "Returning to the starting point of Jaffe's triangle: cooperation between imaging and pathological diagnoses and surgical therapy" was made the keynote theme. The term "Jaffe's triangle" appearing in that theme is an expression at the beginning of *Tumors and Tumorous Conditions of the Bones and Joints*, the bible of bone tumor pathology and classification, published by Professor Henry L. Jaffe in 1958, and is a concept whereby orthopedic surgeons, pathologists, and skeletal radiologists should cooperate in the diagnosis and treatment of bone tumors. In the Society for Musculoskeletal Tumors in the 1970s mentioned earlier, orthopedic surgeons performed all X-ray diagnosis, pathological

Offprint requests to: T. Matsuno
Received: March 17, 2006

diagnosis, and treatment. Although the relationship among orthopedic surgeons, pathologists, and skeletal radiologists has markedly advanced and improved, there are various problems with the relationship, and it is still inadequate. The keynote theme was decided in the belief that this would be a good time to go back to the starting point of Jaffe's triangle and reconsider that relationship. A symposium with the same title has also been planned.

"Limitations of H&E staining and problems of immunohistochemical staining for pathological diagnosis of musculoskeletal tumors" has also been designated as a symposium topic. I want to return to the starting point of H&E staining and discuss pathological diagnosis, which is likely to lead to a bias toward specific staining such as immunohistological staining.

For the treatment of bone and soft-tissue tumors, cooperation with medical practitioners in other fields has become increasingly important, and the symposium and panel discussion have been planned with this in mind. In the symposium "Postoperative quality of life (QOL) of patients with malignant musculoskeletal tumors: release from disability," I am planning to invite patients who have undergone surgery for malignant musculoskeletal tumors to participate, and to discuss what orthopedic surgeons should think and do from the patients' perspective to improve postoperative QOL, with prosthetists also taking part. Treatment should no longer be performed in consideration only of therapy for malignant musculoskeletal tumors, but, rather, in consideration of postoperative QOL as well. For the future treatment of malignant musculoskeletal tumors, consideration of the patient's QOL involving nurses, physical therapists, and those in other medical fields, such as prosthetists, is important, expanding Jaffe's triangle to a pentagon and hexagon. In addition, I want to turn the spotlight on terminal and palliative care for patients in whom surgery or chemotherapy unfortunately cannot resolve the tumor.

For the future of orthopedic therapeutic strategy for musculoskeletal tumors, it is time to reinvestigate surgical procedures (preservation or dissection/amputation of the affected limb, and indications of minimally invasive surgery) to promote active participation in sports and other activities after remission, and to introduce terminal medical care based on consideration of patients' QOL, not simply targeting 5- and 10-year survival rates.